IN THE SUPERIOR COURT OF WASHINGTON
FOR THE COUNTY OF KING

In the Guardianship of:	)	Case No.
	)	
	)	INITIAL PERSONAL CARE PLAN
_____	)	
An Incapacitated Person	)	(PCP)
_____	)	

I. ASSESSMENT

Check all that apply in each category:

1. HOUSING COMPOSITION:
   - ___ Lives Alone
   - ___ Lives with Spouse
   - ___ Lives with Children
   - ___ Lives with Relative
   - ___ Lives with Non-Relative
   - ___ Other: _____

3. LIVING ARRANGEMENT:
   - ___ Home Owner
   - ___ Renter
   - ___ Adult Family Home
   - ___ Cong. Care Facility
   - ___ Nursing Home
   - ___ Senior Housing
   - ___ Other: _____

5. FUNCTIONAL LIMITATION:
   - ___ Speech
   - ___ Hearing
   - ___ Vision
   - ___ Walking

2. PRIMARY MEANS OF TRANSPORTATION:
   - ___ Own Car
   - ___ Public
   - ___ Transportation
   - ___ Friend / Relative
   - ___ Other: _____

4. IF LIVES IN HOME – SERVICES NEEDED:
   - ___ None
   - ___ Chore Services (household chores)
   - ___ Other : _____
     _____
     _____

6. PROSTHETIC DEVICES
   - ___ None
   - ___ Walker/Cane
   - ___ Wheelchair
   - ___ Hearing Aid
   - ___ Artificial Limb
   - ___ Dentures

7. NEEDS ASSISTANCE FOR:

___ Eating
___ Toileting
___ Ambulation
___ Transfer
___ Positioning
___ Personal Hygiene
___ Dressing
___ Bathing
___ Self Medication
___ Travel to Medical Service
___ Essential Shopping with IP
___ Essential Shopping for IP
___ Meal Preparation
___ Laundry:
___ Facilities in Home
___ Facilities out of Home
___ Housework

8. NEEDS ASSISTANCE TO LEAVE HOME:

___ Yes
___ No

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Circle one of the following codes for each item listed below:

Y=Yes; N=No; CD=Cannot Determine.

	Y	N	CD
9. INCAPACITATED PERSON'S ABILITY TO HANDLE EMERGENCIES:			
Knows what to do in the event of a fire.	Y	N	CD
Knows what to do in case of medical emergency (doctor, ambulance).	Y	N	CD
Knows what to do in the event of a break-in or robbery.	Y	N	CD
Knows how to call emergency telephone services (911).	Y	N	CD
10. INCAPACITATED PERSON KNOWS HOW TO SEEK HELP FROM OTHERS TO KEEP SUPPLY OF GOODS AND OBTAIN SERVICES (HOUSEKEEPER, LAWYER, COMMUNITY SERVICES).	Y	N	CD
11. INCAPACITATED PERSON'S FINANCIAL ABILITIES:			
Able to collect benefit, retirement, social security, V.A. benefits.	Y	N	CD
Able to maintain checking accounts with balance greater that $_____	Y	N	CD
Able to pay monthly bills for rent, utilities, etc.	Y	N	CD
Willing and able to spend money for necessary goods and services, i.e. food, clothing, sundries, etc.	Y	N	CD
Able to seek help in money management.	Y	N	CD
Able to manage funds.	Y	N	CD

List sources of income and/or resources to pay for monthly costs and care:

_____
_____
_____
_____
_____
_____

_____

Estimated monthly costs and care:

Housing:	$ _____	Other:	
Food:	$ _____	_____	$ _____
Utilities:	$ _____	_____	$ _____
Clothing and Laundry:	$ _____	_____	$ _____
Medical:	$ _____	_____	$ _____
Recreational:	$ _____	_____	$ _____
Insurance:	$ _____	_____	$ _____

12. INCAPACITATED PERSON'S PSYCHOLOGICAL / SOCIAL / COGNITIVE FUNCTIONING:

Y=Yes; N=No; CD=Cannot Determine.	Y	N	CD
DISORIENTATION:			
Able to relate to person, place or time:	Y	N	CD
MEMORY IMPAIRMENT:			
Can remember events occurring within the hour:	Y	N	CD
Can remember events occurring within the day:	Y	N	CD
Can remember events occurring within the week:	Y	N	CD
IMPAIRED JUDGMENT:			
Able to make appropriate decisions, solve problems, and respond to major life changes:	Y	N	CD
COMMUNICATIONS:			
Able to understand what is being said:	Y	N	CD
Able to express thoughts and needs:	Y	N	CD
WANDERING:			
Moves about aimlessly, or in pursuit of an unobtainable goal:	Y	N	CD
VERBALLY ABUSIVE BEHAVIOR:			
Threatens / berates others, yells, uses foul language, etc.:	Y	N	CD
DISRUPTIVE OR INAPPROPRIATE BEHAVIOR:			
Makes excessive demands for attention, takes another's possessions, disrobes in front of others, inappropriate sexual behavior, etc.:	Y	N	CD
ASSAULTIVE OR COMBATIVE BEHAVIOR:			
Throws objects, strikes or punches, makes dangerous maneuvers with Wheelchair, etc.:	Y	N	CD
DANGER TO SELF:			
Indicated by self-neglect or harm, suicidal thoughts or attempts, etc.:	Y	N	CD
OTHER IMPAIRMENTS IN THOUGHT, MOODS, BEHAVIOR:			
Please Describe:			

_____

II. CARE PLAN

1. RESIDENCE:
Address:

Plan for chore services provided in home (if necessary):

Plan for nursing services and other medical or personal care services provided in home, adult family home, or congregate care facility (if necessary):

Plan for other services, including, rehabilitative, educational, social, and recreational services:

2. TREATING PHYSICIAN:

NAME	ADDRESS	PHONE/FAX NUMBER

_____ _____ _____
__ __ __
_____ _____ _____
__ __ __

1. CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____

2. OTHER PROFESSIONALS ASSISTING INCAPACITATED PERSON:

NAME	ADDRESS	PHONE/FAX NUMBER

1. OTHER SIGNIFICANT PERSONS:

NAME	ADDRESS	PHONE/FAX NUMBER

1. PLAN FOR FINANCIAL MANAGEMENT:
(i.e. person(s) responsible to receive income and pay monthly bills.)

_____
_____
_____
_____

_____
_____
_____
_____
_____
_____

Dated this _____ day of _____, 20 _____.

_____

Guardian for _____